expansion of government programs over the past 20 years, problems developed as well.

- Hundreds of individual categorical programs were developed, each with a different laudible goal and each with its own rules, deadlines, and priorities. Because of the confusion, local administrators and State governors alike have called for simplifying the rules and collapsing the categories.

- Because of the rigidity of national categorical programs, their size and complexity, and their failure to target resources to those who really need them, waste and inefficiency are chronic problems: ineligible people are served, services are duplicated, and some percentage of funds is siphoned off at every level to support bureaucracy.

THE ROLE OF GOVERNMENT

American tradition supports the idea that the primary responsibility for an individual's welfare rests with the individual and his family. When the family is unavailable or incapable of meeting the problem adequately it is appropriate to turn to the neighborhood, community, church, private sector, or government for help.

Government arises from the need to band together to do some tasks collectively that cannot be done by individuals or families. It has always been appropriate for government to play a role when the scope of a problem is such that individuals, families, neighborhoods, communities, or private organizations cannot cope with it. But it is inappropriate for government to arrogate roles that would be more efficiently and sensitively handled without its intervention.

Four questions should always be asked when trying to determine whether a problem requires a government program for its solution: Is it an appropriate area for government? Can government do the job most efficiently? Can we afford the government program? What are the possible adverse side effects of the program?

- *Appropriateness.* — Most Americans probably would agree that government should not do anything that people can do for themselves. When it comes to particular cases, however, much disagreement arises about whether people are managing by themselves, or whether the existence or continuation of a problem means that people cannot handle it and government intervention is needed. This is a philosophical argument that stubbornly refuses settlement. It is sufficient for our purposes to recognize that all agree that government solutions are appropriate when there is evidence that people can't handle a problem themselves, though they may disagree on what and how much evidence is needed to know when this threshold has been reached.

- *Efficiency.* — Although large industries and organizations often can provide economies of operations because of their size, this is usually not true of government programs with their legions of administrators, planners, evaluators, and auditors. When it comes to providing for the unique needs of a frail elderly person or the transportation needs of an elderly couple, a dedicated family or caring neighbor, if available, is more flexible, sensitive, and efficient than even the best-designed government program.

- *Affordability.* — Just as individuals, families, business, and organizations make daily decisions on what activities are affordable, so must taxpayers and their elected representatives at all levels of government. But funding high priority programs often requires reducing funding for those that are of lower priority. The best way to reduce the number of programs that are competing for limited resources is to use nongovernmental solutions whenever possible.
- *Unanticipated or unwanted side effects.* — Just as overreliance on a cane or crutch can slow the healing of an injured limb, the existence of a government program can encourage dependence and overreliance on that program. Some have argued that the existence of Social Security has discouraged saving by making people less concerned about their retirement needs.[1] It has also been argued that extending Medicare and Medicaid to pay families who care for elderly parents at home may result in a tremendous fiscal outflow to pay those families for what they are doing anyway, without substantially increasing the number of families who care for their elderly at home or reducing the number of persons in institutions.[2]

THE ROLE OF THE INDIVIDUAL

The choices individuals make are the most important factors in determining what kind of old age they will have. Most elderly persons who are independent took steps to prepare themselves for old age and preserved their health when they were younger, although it is true that not all old people who need help failed to take such steps, since chance, discrimination, the economy, or simple bad luck can wreck any carefully prepared plan. Nevertheless, it would take an inordinate amount of good luck to override the effects of a lifetime of poor health habits or financial imprudence.

Old age is a payoff stage of life, when decisions made and patterns adopted earlier begin to produce dividends or exact their price. Poor health habits that for many years seemed to be without cost can now show their cost in the form of earlier disability and earlier death, while good health habits can add years to life. Love given to children throughout their growing years is, in most cases, amply repaid. Savings set aside year after year now will have accumulated to a significant sum that can be used to supplement pensions and health insurance to make the retirement years more comfortable and the saver more independent.

It is always difficult for people in their twenties and thirties to pattern their lives on the basis of a future 30 or 40 years away. Still, young people, and anyone else who can, should consider saving a larger fraction of income as the best possible way to prepare for old age. As pointed out in Chapter 2, this will have the added benefit of improving the Nation's future economy — and the Social Security System too — by helping to expand our national productive capacity.

Even actions taken in late middle age or in old age can significantly improve life and life expectancy. For example, some studies indicate that stopping cigarette smoking can lower the chance of heart attack in as little as two months.

Individual actions as simple as marking possessions, installing proper locks on doors and windows, and being careful when on the street can reduce, if not eliminate, a person's chances of becoming a victim of crime. Educational programs can open pathways to second careers or help elderly persons keep current with a rapidly changing world.

A number of new or developing techniques allow older persons to improve their economic position through maximum use of assets, tax advantages, and saving opportunities. The assets represented by a mortgage-free house can often spell the difference between a precarious and a comfortable retirement. In the past, the aged were faced with the unhappy choice of remaining in the residence and foregoing use of these assets, or selling the house and facing capital gains

taxes and higher living costs elsewhere. Changes in the tax law have alleviated the capital gains tax problem, and increased experimentation with reverse mortgages and guaranteed annuity transfers indicates their promise as techniques to unlock another source of regular income in old age. These programs have developed in a number of different forms, but the underlying idea is that people remortgage their homes and receive an annuity from investment of the assets. When the homeowner dies, the mortgagor takes title to the house.

Other changes in the tax code have encouraged savings or have facilitated retention of income by providing an opportunity for the elderly to take steps to benefit themselves:

- *Tax-free saving certificates.* — After October 1, 1981, $1,000 in earned interest ($2,000 on a joint return) from a variety of savings certificates can be excluded from income taxes.
- *Individual retirement accounts.* — All employees, including those participating in pension plans, are now allowed to contribute to an IRA. The new maximum amount that can be deducted by an individual is $2,000 (up from $1,500) plus an additional $250 for a nonworking spouse. If the taxpayer is already in a pension plan, the IRA contribution can be made to the pension plan to increase the taxpayer's equity.
- *Estate tax relief for married couples.* — Before January 1, 1982, surviving spouses had to pay estate taxes on 50 percent of the joint estate of the couple. The tax rates were the same as those for any other estate on the taxable 50 percent. After January 1, no estate tax will be owed by a surviving spouse on any portion of a joint estate.
- *Exclusion of gain on the sale of a residence.* — Taxpayers 55 or over can sell or exchange their home and get a once-in-a-lifetime $125,000 exemption of the gain on that home.
- *Indexing.* — Beginning in 1985, tax brackets will be adjusted for inflation so taxpayers can realize gains in personal income based on cost-of-living increases.
- *Reduced individual income tax rates.* — Several across the board reductions in tax rates have recently been legislated, the first being the 1.25 percent reduction in 1981. A 10 percent reduction is scheduled for 1982, a 19 percent reduction in 1983, and 23 percent in 1984. The maximum tax rate on any income was reduced from 70 percent to 50 percent effective October 1, 1981.
- *Credit for the elderly.* — Under certain conditions, individuals over 65 and those under 65 and retired under a public retirement system may be able to claim a credit and reduce their tax liability by as much as $375 (single) or $562.50 (married filing jointly).
- *Additional exemption for age and blindness.* — Individuals can always take one exemption for themselves. If they are over 65 they can take a second exemption, and if they are also blind they may take a third exemption. The same exemption rules apply for spouses if filing a joint return.
- *New Exclusion for interst and dividend income.* — At this time, $200 ($400 if married and filing jointly) of qualifying interest and dividend income can be excluded from the adjusted gross income calculation.
- *Nonreporting of income.* — Under current Federal Tax laws certain income sources need not be reported. They include Social Security benefits, disability retirement payments and other benefits paid by the Veterans Administration, dividends on veterans' life insurance, and life insurance proceeds received because of a person's death.

An important feature of all these tax changes is that government action has provided the opportunity, but individual initiative is required if the potential benefit is to be realized.

States, localities, and private organizations are also providing potential benefits to older Americans as the following examples show.

Tax freezes. — The State Legislature in Connecticut, in cooperation with various city councils, has changed its tax policy to relieve older homeowners of increased property tax burdens after age 65.

Property tax deferrals. — Six States have instituted tax policy changes that allow older persons to defer tax payments until property is sold and more resources are available.

Homestead exemptions. — Forty-one States have changed their tax codes to relieve older persons of some tax burden by reducing assessments.

Circuit-breaker taxes. — Thirty-five States have relieved older pesons of some property tax burden by reducing payments according to income.

House sharing. — Many cities have directed their housing departments to institute programs enabling two or more individuals to share house expenses.

Group living. — Non profit organizations in many cities have promoted self-help among the elderly by enabling groups of them to live together and share expenses as well as find companionship.

From these examples it is clear that individuals have numerous opportunities to prepare for a comfortable and secure old age, if they are able to use them.

An additional aid that will develop during the next few years is the increasing value of older workers to the economy. As discussed earlier in this report, the reduced birth rates of the 1960s and 1970s will produce a labor shortage that will make older workers more attractive to employers. Incentives for older workers to remain in the workforce will increase, and this will have the double advantage of taking some pressure off the Social Security system and keeping more people fully integrated in society longer.

Most people in their sixties have no problems of health or competence that require retirement. And there is no reason to believe, for most people, that passing 65 or 70 brings infirmity or dependence or need for extra services. These services should be available for those who need them, and they should be delivered fully, promptly, and efficiently.

THE ROLE OF THE FAMILY

The role of the family is complex and embodies numerous components — economic, social, psychological, philosophical, biological, and spiritual — none of which alone can fully describe its functions. In describing the role of the family with regard to the aged, it is possible to catalog roles and responsibilities using the categories of government programs: provide economic security, serve as caregiver, provide transportation services and so forth. But this categorization of the help that families can and usually do provide to their older members is unnecessary. Simply put, families, to the extent that they can, will provide the support their older members need, including financial advice and assistance, transportation, help with chores or decisionmaking, or whatever other aid a parent or older relative needs.

But the family role becomes even more important when older persons grow less independent because of insufficient savings or income, illness, or increasing frailty. Families have always provided this kind of help to their older members. Before the growth of government programs, families were the major — in many cases the only — source of help and support. In earlier societies, older members stayed with their children, gradually changing their status from leader to advisor until eventually their health failed and they needed care and assistance. People

without families often had no one to care for them, at least until the development of poor farms and charitably supported private institutions.

Federal programs to aid and support the elderly developed after the depression of the 1930s, a period of physical and economic dislocation that overwhelmed many families' ability to provide the kind of assistance to their older members that had been taken for granted 10 years earlier. During the next 40 years, a range of government programs was developed covering the same kinds of services that a family would have provided, virtually alone, in earlier years.

These programs are needed. They provide services for people who do not have families to help them. And they provide support when the family's economic and emotional resources are overwhelmed by serious problems. But government programs should be designed and scaled to reinforce, not replace, family efforts. Caregivers paid by government funds simply cannot provide the personal service that a loving family can. And government programs can never be flexible enough in their rules and regulations to provide the exact service that older persons need at different times.

Most important, we as a Nation can not afford to replace family care with government-funded care. It has been estimated that over 80 percent of the care provided to the elderly is provided by informal caregivers, usually families, without pay or reimbursement. Public policies that would reimburse family members for service to their older members, or would discourage families from providing such care in favor of more publicly-funded, publicly-provided care, would add untold billions to the budget.

When the ratio of producers to dependent aged is high, it may make sense to tax everyone to provide services centrally to the small number of elderly who need them. But as the ratio decreases, the "insurance" aspect of the programs decreases as well; instead of taxing a large number of producers a small amount each to provide benefits for a small number of recipients, a smaller number of producers must be taxed at a high rate to provide government services for a relatively large dependent population.

A better alternative is to count on families to provide a larger share of the help and support for the elderly, and to reserve governmental assistance for those who have no family or whose families lack the necessary resources.

FRIENDS, VOLUNTEERS, AND PRIVATE NONPROFIT ORGANIZATIONS

If the growth of government programs has threatened to replace family responsibility, it has had an even greater effect on the role of the community, neighborhood, and private voluntary and charitable organizations. The perception has grown that these are no longer needed, that government programs are providing everything necessary. Government programs decidedly are not providing everything necessary. Private efforts not only can provide the same services at lower cost and without red tape, they are better at providing some services than the government.

Transportation is an area where the private sector, State and local governments, and the Federal government all have roles. Due to economic necessity, privately-owned transportation systems are increasingly concentrating on their most profitable routes and dropping or decreasing service on the less profitable ones. The rural elderly in particular are adversely affected, since rural transportation routes are usually the least profitable.

Public ownership of mass transit has expanded over the past 30 years in both municipal and regional systems. The public systems have tried to restore the services dropped by the private companies, but economic problems at these levels of government have prevented them from doing all they would like. In many urban areas governments have provided excellent dial-a-ride

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services, and these should be continued and expanded where possible. The Federal Government has subsidized the development and operation of transit systems, but its aid has been focused mainly on high-use systems and routes.

For occasional travel, particularly in rural areas, the best solution will probably continue to be a friend or neighbor. Churches and community groups can help organize this approach by using sign-up sheets and recruiting volunteers to drive one day a week.

Social services is another area in which the role of the nongovernment sector is strong. Government recognizes that these organizations have flexibility that even well-run and well-intentioned government bureaucracies do not. Much of the government-funded social service activity is in fact performed by the staffs of private social service organizations operating under contract with the government.

These agencies should be supported not just with tax dollars but by direct contributions of money and time, for the more they are forced to rely on government funds the more like government bureaucracies they will eventually become. Conversely, if they can rely more on an independent source of income they will be better able to retain their traditional flexibility.

Nongovernmental efforts can also have a large payoff in the area of crime protection. Programs like Neighborhood Watch extend the capabilities of local police and provide a feeling of security for older people.

Education, recreation, and cultural activities are important for maintaining physical condition, mental alertness, and social contact. Education helps older people keep up with a rapidly changing world. While advances in cable and satellite television systems promise a broad range of new educational experiences at home, the value of person-to-person discussion and the need to focus some educational activities on local issues means that community discussion groups and other informal education will remain important.

Recreation and cultural activities are best managed on a local, nongovernmental basis because personal preference plays such a large role in determining individual participation. A variety of different activities run by different organizations or informal groups is likely to please more people than a large program run by government.

Churches serve the elderly in many ways. In addition to their primary role of providing organized worship, they sponsor many activities that bring elderly together with their peers as well as with younger people. Clergymen are often excellent counselors, and other members of the congregation are often willing to help older members in time of trouble.

Voluntary organizations tend to be extremely sensitive to real needs precisely because they are voluntary. The decision to volunteer time and money is personal, and the voluntary agencies or groups have complete discretion in choosing their issues and targets with no political constraints or bureaucratic regulations. If a voluntary or charitable organization wastes time or money, or if it focuses on marginal problems, its funds will soon dry up and its volunteers will drift away. The voluntary sector, whether represented by a national organization or a single concerned neighbor, can be counted on to operate efficiently and responsively and to resolve problems that "fall through the cracks" of clumsier, more constrained government programs.

THE ROLE OF THE BUSINESS SECTOR

Although it provides by far the most goods and services Americans receive, our private, for-profit sector receives surprisingly little attention in considering ways to meet people's needs, including those of the elderly. We tend to focus on government, though the free enterprise system in most instances is best capable of performing this function.

The business sector of our system has the advantage of being able to respond automatically to our changing demands and preferences. It operates without all the difficulties inherent in public programs, such as appropriating the "correct" level of funds, proper targeting, excessive administrative expense, and conformance to a particular political ideology. Unlike our public programs, the for-profit sector does not waste funds by providing people with services they neither want nor need. And for the most part it operates efficiently, effectively, and with minimal oversight.

It is essential that we do not unnecessarily inhibit the free enterprise system's ability to provide needed goods and services.

The private sector often has much to offer in areas we generally regard as a purely public responsibility. An example is crime prevention, a major concern of Americans, especially the elderly. In response to this concern, housing projects are now being designed to make it difficult for a criminal to enter a residence without being seen by a neighbor. Improved window and door locks are another way the market has responded to the crime problem. Fire protection has also been vastly improved through the production of easily installed and inexpensive smoke alarms, which have already saved hundreds of lives.

The free market system provides the best mechanism to meet many of the needs of the elderly. As the absolute number of elderly Americans increases and their proportion of the population grows, the private sector can be counted on to pay increased attention to their needs and interests.

STATE AND LOCAL GOVERNMENT

State and local governments are responsible for more than managing and accounting for Federal funds they receive. They also have the responsibility to make themselves aware of conditions affecting their older citizens and to exercise leadership so old problems can be resolved and new opportunities can be created.

School districts should think creatively about ways to serve the middle-aged and the elderly. The rate of technological change has accelerated to the point that many would benefit from refresher courses that explain new technology or prepare people for new careers. At a time when school enrollments are falling and pressures are building to close schools and eliminate programs, increased attention to career development and continuing education would bring together a growing need and a resource in good supply.

Transit authorities should be aware that the travel needs and schedules of the elderly often differ from those of commuters. In some cases, routes, schedules, and fares can be adjusted in the middle of the day to accommodate elderly riders without substantially raising costs or affecting the quality of morning and evening commuter service.

Police forces are hard pressed and there is little that can be suggested here to improve their effectiveness, but we hope they will continue to remind people of the steps they can take as individuals to deter crime and the steps that communities can take to make their neighborhoods safer. Judges and juries should become more aware of the terrible effect of crime on the elderly-that it not only takes their savings and threatens their lives and health,

but that fear of crime makes them more isolated, less able to trust others, less willing to travel the streets alone, less independent. They should consider these additional factors when setting bail or deciding on a sentence. Some States have passed Victim Impact laws, which require judges or juries before imposing a sentence to read a statement detailing the effect of the crime on the victim: financial losses, hospital or medical expenses, lingering health problems resulting from the crime, and psychological effects.

There are many opportunities in the housing area for State and local government leadership. Laws authorizing and governing reverse mortgage plans, zoning ordinances permitting group housing or construction of "granny flats," real estate tax reductions or deferrals, all represent areas in which some States and communities have taken action; changing demographic patterns and changes in the economy are making certain policies desirable that only a few years ago were rejected by most people and most communities. Likewise, some housing and development goals encouraged by ordinances passed 20 years ago are now seen as inappropriate because of energy cost increases, inflation, and changing demographics. States and communities should seriously consider changing some laws that are no longer needed, but they should do so carefully so as not to throw out needed protections in their search for new flexibility.

THE FEDERAL GOVERNMENT

Federal support for the elderly is and will continue to be strong. While the elderly comprise about 12 percent of the total population, they receive approximately 28 percent of Federal budget outlays. Federal support for the elderly will average over $7,500 per individual in fiscal year 1983. This more than doubles Federal spending on elderly programs in fiscal year 1978. Over the next five years, Federal spending for the elderly will increase 125 percent as fast as overall Federal spending.

The Federal Government will continue to exercise its responsibilities. Several of these — including preserving the Social Security system, encouraging good health habits and reducing health care costs, and supporting research on issues related to the aging — are discussed in other chapters. The Federal Government will also provide services and protections to those who truly need help: those who cannot care for themselves, and for whom family, community, or State assistance is not enough. It will continue to support the activities sponsored under the Older Americans Act. These programs provide a range of services often not provided by other programs. And it will support expansion of the protections afforded in the Age Discrimination in Employment Act through the elimination of mandatory retirement.

Retirement should be a bilateral agreement between an employee and an employer. Amendment of the law in this way may be the most significant step of all in achieving our avowed goal: to give older Americans maximum freedom of choice and encourage their continued integration in society, in the workforce, in the business of America, for as long as possible.

RECOMMENDATIONS

Services

- Efforts to target Federal resources on older persons most in need should be expanded.
- States and localities should be encouraged to improve access to existing services for older persons, rather than create separate service delivery mechanisms for the elderly.
- The Department of Health and Human Services should continue to work with Federal Departments, organizations and voluntary groups to assure that appropriate services are available to elderly persons in need.
- States and localities should be encouraged to promote and maintain intergenerational activities and to integrate the elderly into existing service programs.
- Public and private agencies serving the aging should be cognizant of the particular needs of minority populations, including blacks, Hispanics, Asian Pacific Americans, and Native Americans.

Housing

- The Federal Government should work with private sector, State, and local governments to explore housing options for older persons. This exploration should include analysis of innovative financing, construction, and living arrangements.

Transportation

- Transit authorities should explore ways in which the needs of the elderly can be met — such as mid-day route and fare adjustments — without increasing the costs or decreasing the quality of rush hour service.

Voluntary

- Programs to encourage voluntary service by the elderly should be encouraged by both the public and private sectors.

Education

- Educational programs, under a variety of auspices, should be available to older men and women and should provide skilled training, job counseling, and job placement, all of which will enhance their ability to stay in or rejoin the workforce or to enhance second careers.

Crime

- Older persons should be encouraged to play an active role in crime prevention and should be made aware of the steps they can take to minimize the risk of being victimized.

REFERENCES AND NOTES

1. See Martin Feldman, "Social Security, Induced Retirement, and Aggregate Capital Accumulation." Journal of Political Economy, Vol. 82 (1974): 905-926.

2. For a discussion of this issue, see Long Term Care: Background and Future Directions. Health Care Financing Administration Publication No. 81-20047.

Chapter 5

RESEARCH

INTRODUCTION

We Americans have a deep conviction that research will bring us continuing benefits — longer lives, healthier lives, better lives, and better and less expensive services. Our national commitment to research has brought remarkable success in all of these areas, except in the control of the costs of medical care services.

It is often said that the growth of longevity in the United States is due to medical achievements that have reduced the toll of childhood diseases. New developments make that explanation only a partial one. Statistical studies have made it clear that in recent years longevity improvements for adults have exceeded those for children.[1] In the 50 years from 1900 to 1950 life expectancy at birth increased by 38.4 percent while life expectancy at age 45 increased by only 14.9 percent.[2] In the 30 years between 1950 and 1980, however, life expectancy at birth increased by only 8.1 percent compared with an increase of 12.6 percent for life expectancy at age 45. Between 1970 and 1980 the age-adjusted death rate declined 37.4 percent for stroke and 19.0 percent for heart disease, our third and first leading causes of death respectively.[3]

The changing statistics reflect medical advances. Each year, for example 65,000 Americans find new freedom of mobility as well as freedom from pain by receiving artificial hip joints. Pacemakers, coronary bypasses, organ replacement, insulin pumps, and a long list of other recent medical breakthroughs have given new life to tens of thousands of adults. Each of these improvements can be traced directly to research. There is every reason to expect research benefits in the future to be as great as those we have reaped in the past.

That we can and must continue to progress was assuredly the viewpoint of both the 1981 and the 1971 White House Conference on Aging. Yet there were important differences in emphasis between the two Conferences.

A review of the recommendations for research on aging made by the 1971 Conference provides a useful perspective. That Conference met when inflation was little more than a word in the dictionary (except in the area of medical care where it was already quite noticeable), the "energy crisis" was not even dreamed of, and President Johnson's Great Society programs were well underway. Our confidence in our government's ability to improve our lives through research was perhaps at its zenith. The 1971 Conference recommended:

1. A *National Institute of Gerontology* to support and conduct research and training in the biomedical and social-behavioral aspects of aging.
2. An *Executive Office on Aging* with authority to develop and coordinate programs for the aged at all levels of government, including research and demonstration programs, and to oversee their translation into action.

3. A *major increase in Federal funds* for research, research training, and demonstration projects in the field of aging, the projects to be funded by no less than 3.5 percent of general revenues appropriated for programs in the interest of older persons.

4. *Funding of research, research training, and demonstration projects* on aging to be allocated to racial and ethnic minority groups in proportion to their numbers in the total population, with attention to recruitment and training of minority group students to become competent researchers in gerontology.

5. *Recruitment and training of women* and representation of women on bodies with responsibility for allocating training and research funds.

6. A *clearinghouse* to collect and disseminate current research findings in the field of aging to practitioners in the field and to the general public.

7. *Prompt allocation* of appropriated Federal research, demonstration and training funds and prompt implementation of intramural and extramural programs supported those funds.

8. *Assured continuation and funding* of Federally-funded demonstration projects that have proved successful.

These recommendations of the 1971 Conference focused mainly on the resources necessary for research and the organization of research. Several of the recommendations have been met. The National Institute on Aging was established in 1974, its budget has increased each year, and its 1983 budget will reach $84 million. The problems suggested by Recommendations 7 and 8 are largely resolved. Recommendations 2 and 3 were not met, and marginal improvements have been made on 4, 5, and 6.

It is interesting to note the lack of specific reference to several subjects that were important to the 1981 delegates: disease prevention, work opportunity for the elderly, the need for a continuum of long-term care including in-home care, and medical care costs. Perhaps these issues were discussed in 1971 but were not incorporated into the recommendations. Or perhaps the issues so important to the 1981 delegates were not considered significant in 1971.

It could also be hypothesized that in 1971 there was little sense of fiscal constraint, so no attention was given to priorities for research or acknowledgement of the choices that might be necessary. In 1981 there was definite indication that resources for research were of concern to the delegates. The recommendations on specific types of research and training to be funded far outnumbered those concerned with research resource development and organization of research. And while the 1981 Conference recommended that the government match the private sector's commitment to research, the 1971 recommendation that 3.5 percent of revenues for programs in the interests of older persons be allocated for research and training had, in 1981, been reduced to 2 percent.

The 1981 delegates further recommended that, "Funds for research should not be allocated at the expense of funds to beneficiaries in those programs that are being studied." Thus the delegates exhibited a very high sense of responsibility to the needs of the elderly, as well as awareness of the fiscal problems now facing the country and the likelihood that choices among the recommendations might be required.

Choice among research and training options is a continual issue in the development of government budgets. Choices may be based on cost-benefit criteria or on very subjective impressions or on a combination of both. In considering how to divide funds between competing research needs, the issues can become extremely complex. Is is not easy to decide how to allocate between competing research needs: resource development versus execution of research; basic versus applied research; research that extends life versus research that improves its quality; research to reduce government program expenditures versus research to improve

services to the rural or minority elderly; research with short-term payoffs versus longer-range research; prevention research versus research on cures versus rehabilitation research. Although cost-benefit analysis might be the preferred approach, we lack the knowledge to resolve all the questions that might be raised concerning choices and priorities. Ultimately, consensus about the allocation of research resources must be achieved through interaction between the Executive and Legislative branches of government during the budget development process.

TOWARD A RESEARCH POLICY ON AGING

This national policy for research on aging is based on the following premises:

- *Federal budgetary restraints will not significantly retard the rate of research progress.* Federal research dollars for aging have increased rapidly in recent years but have slowed for the past two. However, we can expect continued research productivity. We have the resources: trained researchers have never been more plentiful; our data bases are more complete than ever; and rapid advances in computer technology have given us better information processing capabilities than we had in the 1970s. Better use of resources and better coordination will make our research efforts more effective in the years immediately ahead. Nevertheless, dollars remain an important requirement for research on aging. Severe underfunding of any element — manpower training, information bases, data processing capability, and new basic and applied research — could be very damaging.

- *Distinct boundaries cannot be drawn between research on aging and other kinds of research.* The sharp decline in death rates from several diseases of adult life is due to research progress on many fronts, not just in the field of aging. The National Center for Health Statistics estimates that the total eradication of cancer would increase average lifespan in the United States by 2.4 years, yet the billion dollars budgeted annually to the National Cancer Institute is not classified as aging research. Similarly, research on housing for the poor and on the other social programs usually benefits the aged along with other groups. Our perspective on the kinds of research that will benefit the elderly should not be too narrow.

- *Laboratory and clinical research demonstrations, and evaluations, as well as studies designed to reduce program costs are all relevant to our older population.* For the purposes of this discussion, no distinction is drawn between these activities.

- *Other institutions besides the Federal Government are involved in research related to aging.* Although most biological and social research related to aging is supported by Federal funds, other levels of government and the private sector make significant contributions and are important resources.

MAJOR FUNDING SOURCES FOR AGING RESEARCH

Although a very substantial amount of age-related research is done by the pharmaceutical industry, most of it is funded by the Federal Government, principally the Department of Health and Human Services.

Within HHS, the National Institute on Aging leads both in dollar amount and in variety of age-related research activities, but other agencies of the Department are also involved. The National Institute of Mental Health, for example, funds intramural and extramural research on mental processes. The Health Care Financing Administration funds research and demonstration projects relating to Medicare and Medicaid. The Social Security Administration, the Office of the Assistant Secretary for Planning and Evaluation, the Center for Health Services Research, the National Center for Health Statistics, and all the Institutes of the National Institutes of Health also fund and conduct research that is relevant to the aged.

Numerous other Federal agencies and departments, including the Veterans Administration, have active research programs that study age-related problems. Most of these programs are relatively small and are often quite specialized, depending on the agency's mission.

NEEDED RESEARCH IN SOCIAL AND ECONOMIC AREAS RELATED TO AGING

Designing a sensible and effective National Policy on Aging requires a great deal of information. We need to study retirement, the retired population, and the institutions that support that population. We need to find the best ways to design programs to serve the diverse and changing needs of this group. We need information on the number and nature of the elderly, now and in the future. We need to know how the institutions that support the elderly — particularly those that provide retirement income — affect the well-being of the elderly and the economy as a whole. Specific areas needing research are discussed in this section.

Research on Work Opportunities for the Elderly

The right to work in old age was a major theme of the 1981 Conference. A Conference Committee recommendation to abolish mandatory retirement and allow the elderly to continue working if they want to received the strongest support of any recommendation in the post-Conference survey of delegates. This recommendation is also supported by the President. The age at retirement was also identified as a critical issue earlier in this report. Chapter 1, dealing with the economic implications of an aging population, showed that retirement age affects national productivity and the strength of the Social Security system.

Developing effective policy in this area requires research. Before we can design programs and policies to structure workplaces and jobs to accommodate older workers, many questions have to be answered. For example: What factors produce social competence and personal satisfaction in later life? What can government and private organizations do to promote employment for the elderly who want to work? What are the best ways to increase the use of part-time jobs and flexible or phased retirement for older workers? How do various aspects of health, impairment, and disability relate to employment?

To promote work opportunities for the elderly we need better information on the future size and characteristics of the older population as well as better understanding of the economic and social factors that influence the decision to retire or continue working, the factors that affect employers' demand for the labor of older workers, and the effect on worker productivity of advancing age. All of this behavior may be substantially influenced by government regulation,

tax and transfer policies, and the practices of employers. The cumulative impact of these influences during individuals' working lives could have major effects on the character of the retired population, the rest of society, and the economy.

Finally, we need better information on how retirement income programs affect the economy through their effects on aggregate labor supply. Do the savings effects of these programs influence capital formation and productivity? How will the financial markets and the economy be affected when the baby boom generation retires and begins to draw down the reserves of pension funds?

Research on Competition in the Medical Care Delivery System

Chapter 3 discussed some of the problems in our health care delivery system and how these problems are increasing medical care costs. Clearly, changes must be made if the aged are to be assured affordable medical care.

One way that has been recommended is to stimulate competition in the health system. Past research has laid a solid foundation of information on how the health system functions and has suggested the role that competition could play, but greater depth of knowledge may be needed about how consumers, providers, and insurers would respond to the incentives of a more competitive health care market.

Research is also needed to generate information in the public domain to help the private sector improve efficiency in health care financing and delivery. Current policy relies heavily on the private sector for innovations that enhance efficiency. Rather than attempt to control the private sector through regulation, current policy is to remove impediments to allow private sector activities to move freely in desired directions. Information provided by research can help the private sector make informed decisions.

A 1982 report prepared for the National Center for Health Services Research identified five specific research topics relating to competition in the health care system: the effects of (1) greater out-of-pocket payments by consumers; (2) changes in taxation of employer-provided health benefits; (3) the spread of health maintenance organizations and other alternative delivery systems; (4) changes in insurance programs; and (5) changes in the nature and extent of regulation in the health system.

Discussion of each of these topics is beyond the scope of this report, but some general remarks can be made about the current state and direction of research in these areas. In some cases, very little is known about how certain reforms would change behavior in the market. For example, little information exists on how novel developments such as business-health coalitions, preferred provider plans, and company-administered "stay-well" plans are affecting health care expenditures. In many cases we know the direction of the effect that would be produced by a certain reform but not its magnitude. An example is the extent to which less preferential tax treatment of employer-paid health benefits would deflect the trend to ever more expensive "first-dollar" health insurance.

Despite these uncertainties, it would be incorrect to assume that nothing or very little is known about the health care market's likely response to new incentives. In fact, much of past health services research is entirely relevant to current health policy deliberations, and part of the task of current research is to synthesize those past findings so they can serve as a foundation for new research.

Both the private and public sectors have roles to play in producing new information on the prospects for the consequences of a more competitive health system. Even now, some of the research budget of the Department of Health and Human Services is devoted to investigating competition-related issues, and part of this activity is to discover information being produced in the private sector and determine its implications for developing competitive reform in health care financing and delivery.There is much more to be learned in this rapidly changing area.

Research on Long-Term Care

Long-term care for the elderly involves principally the fast-growing population age 75 and over. Although the rate of increase in this population is diminishing (see Table 1), it is nevertheless sufficiently high to alert us to the increasing need for long term care services.

The costs of long-term care have been the fastest growing of any in the health sector and are projected to have the fastest growth for the remainder of this century.[4] This growth is due not only to the increasing size of the aged population but also to the Kerr-Mills and Medicaid programs of the 1960s. Because of the growth of these programs and occasional scandals in the care provided to elderly nursing home patients, a strong call has been raised for alternatives to the institutionalization of the disabled elderly.

The institutionalized elderly person today tends to be a woman who has outlived her husband. Prior to institutionalization she was poor and lived alone. She was unable to purchase the services she needed and had no one at home to provide for her. She was admitted to a nursing home from a hospital. Another person with the same medical condition, but with money or a caregiver, might never require a nursing home. The first patient would require considerably more assistance to avoid institutionalization than the second.

It is widely believed that many nursing home patients could be cared for in their own homes if services could be provided to them there. This belief was reflected in the post-Conference survey of delegates: the second and third most favored recommendations that emerged from the 1981 Conference were expanded home health care and in-home services, and tax incentives for family care of elderly relatives at home.

Over the past several years the Department of Health and Human Services has funded a number of projects throughout the country to allow States to study and develop systems for home and community care. The Department and several States (using their own funds) have also conducted experiments to see if sufficient care can be provided to the impaired elderly in their homes. A number of home or community care demonstration studies have also been carried out, and many are currently underway. Although few results are yet available, there is high interest in the home-care alternative. Congress, in Section 2176 of the 1981 Budget Reconciliation Act permitted the States, under certain conditions, to establish home and community care programs as substitutes for skilled nursing and intermediate care facilities. A number of States are making use of this opportunity.

The final results of these efforts are not yet in, but preliminary analysis by Stassen and Holanhan[5] shows mixed results: the quality of life for patients is probably improved but costs are probably higher. The authors state:

> From the review of community-wide coordinated care demonstrations, day-care programs, and in-home service programs, we have concluded that there is only a limited amount of evidence that community-based services substitute for institutional care...[T]here is little direct evidence of overall cost reductions resulting from the use of community-based services... In sum, community-based services appear to have a generally better impact on outcome than institutional care. Whether these improved outcomes are worth the costs is a political or social judgment well beyond the scope of this report.

These studies are designed to demonstrate that patients who would otherwise require institutionalization can be effectively treated in their own homes at less cost if they are provided services available in their communities. The most difficult aspect of these programs is the screening of candidate patients to accept for home and community care treatment only those who would otherwise require placement in an institution. Too often in these studies patients selected for home care, though impaired, would never have sought nursing home care, so the identified savings are illusory. If the patients actually requiring institutionalization could be

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precisely identified and successfully treated at home, this would presumably result in lower nursing home occupancy rates. This has not occurred, and since most advocates for home and community care do not anticipate that it will, it appears quite possible that the home and community care movement will result in an additional set of services without counterbalancing savings in nursing home services. Society may well be willing to pay this price. This would create a new community health care and social services delivery system that could grow to a very substantial size.

Additional research findings are rapidly becoming available, and some of them will provide at least provisional answers to many of these questions. The area deserves and must receive thorough attention by researchers, policymakers, and legislators. It is critical that we learn more about these new home and community care systems to ensure that they provide the needed services at acceptable costs. Otherwise, in today's tight fiscal environment, they will be unable to survive.

NEEDED RESEARCH ON THE BIOMEDICAL ASPECTS OF AGING

Disease Prevention and Health Promotion

Research is needed on appropriate measures to retard the rate of biological decline associated with aging, to prevent or delay the onset of chronic disease processes, and to evaluate biological and psychological factors that contribute to the maintenance of health and well-being of the elderly. Many of the health problems that result in loss of independence among the elderly could be avoided by heightened health awareness during the middle years as well as during old age. Examples include improved nutrition, physical fitness and exercise, control of stress, and the effects of social networks on health. Research opportunities, as well as efforts to increase public awareness and transfer existing knowledge to health professionals, must be pursued.

Improved biological markers are needed to measure physiological age for comparison with chronological age to permit better studies of aging and the effects of more healthful lifestyles.

Dementias of Aging

Approximately 3 to 4 million elderly Americans suffer from dementia, often of the Alzheimer's type. This disease of unknown etiology is characterized by intellectual deterioration and inability to carry out the tasks of daily living. It is the consensus of the biomedical community that dementias of aging are not an inevitable consequence of growing old but are disease states that can be understood and remedied. The human and health care costs of senile dementias call for a major research initiative aimed at prevention, specific diagnosis, and treatment.

Understanding the Aging Process

Research is needed to understand the physiological decline that accompanies aging and renders biological systems increasingly less efficient and more susceptible to disease. The goal of this research is to retard the aging process.

Bring Geriatrics into the Mainstream of Academic Medicine

New knowledge must be developed to diagnose and treat the diseases and disabilities of old age, with emphasis on the major sources of morbidity and mortality among the elderly, including dementia, incontinence, musculoskeletal disorders, pneumonia, fall injuries, nosocomial infections, and decubitus ulcers (bed sores). Integral elements of this research

emphasis are the development of a cadre of health care professionals competent in geriatrics and movement of geriatrics into the mainstream of U.S. academic medicine.

RESEARCH RESOURCES

The Research Committee of the 1981 White House Conference on Aging emphasized the importance of resources for research on aging, the need for long-term Federal commitment to their support, and flexibility to develop new resources to respond to advances in the field and the changing needs of investigators.

A program for research on aging should address three kinds of resources for research capability: institutional, human, and physical.

- *Investigators and their institutions* are the heart of scientific inquiry. Research activity at academic and other institutions must be fostered and research support provided in a stable manner.

- *Training of new researchers* is essential to sustain a healthy research capability into the future. As stated earlier in this chapter, current fiscal constraints are temporary and will improve with the economy. and thus will not significantly retard the rate of research. Like research money, funds for training will also feel the squeeze, but we must not neglect this key to our future research potential.

- *Critical tools* for aging research include such specialized resources as libraries, census statistics, a variety of data bases and equipment to process them, genetic and cell culture resources, and animal models, as well as human populations for clinical, sociological, and epidemiological studies on aging. It should be recognized that these types of resources must be maintained over time.

HEALTH CARE PROFESSIONALS IN AGING

The increase in the aged population will require more trained geriatricians as well as other professionals and paraprofessionals for service in hospitals and long-term care facilities, including teaching nursing homes. Teaching nursing homes, affiliated with established medical centers, are an important new concept that responds to an acute need in our society. Careful study should be given in the implementation of this concept, however, in order to avoid a narrow concentration on the medical model to the exclusion of a broader sociomedical model that also incorporates in-home and community services.

CONCLUSION

It has been said that more than death itself we fear a long period of suffering and debility before death. Above all, we wish to avoid the lingering terminal illness. The ideal life would be years of interested active involvement with our community, job, friends, family, and spouse, ending in no more than a very brief illness. Although it has not been thoroughly documented,

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there is good evidence that over the past several decades we have been moving toward this ideal.[6]

Thanks in part to epidemiological and biomedical research, more and more of us in recent decades are approaching what may be our maximum, genetically programmed life span, when, having survived childhood and not succumbed to some chronic disease as adults, we reach the point when a number of our body systems simply wear out and quit working.

Research will aid the continuation of this favorable trend, of course, but improvement of our own individual health habits will do far more to give full and healthy lives than any amount of research. Life expectancy for 40-year-olds increased less than 5 years between 1940 and 1980, despite spectacular research and medical advances in that period. In contrast, epidemiologic studies have shown that our patterns of daily living have a very powerful effect on our health and longevity. Belloc and Breslow[7] found that the best practices to promote health and longevity were 7-8 hours of sleep each night, eating breakfast daily with only occasional snacks between meals, being neither excessively underweight nor overweight, frequent physical activity, avoidance of excessive alcohol, and the less smoking the better.

Belloc[8] found that these relationships held for the elderly as well as the young and that the improvement of even a single habit can be beneficial. Forty-five-year-old men who follow six or more of these good practices will average 11 more years of life than men who follow three or fewer. For women, the difference is 7 years. These added years of life exceed the overall improvement in longevity between 1940 and 1980.

The message from these studies is clear: those of us with poor habits have the opportunity to live longer if we choose; we have a great deal of ability to determine how long and how well we shall live. The major chronic diseases—heart disease, cancer, stroke—are more easily prevented than cured. Though we as a society continue to give biomedical research a high priority, our highest priority as individuals must be our responsibilities to ourselves.

RECOMMENDATIONS

- The Department of Health and Human Services should improve its coordination of overall strategy for its research on aging to ensure that priority areas are adequately funded and that duplicative research activities are avoided.
- Research in disease prevention and health promotion should receive the highest priority. The knowledge we already possess must be exploited. New studies are needed to establish improved biological markers of physiological age. Study of the personal motivators for improved health habits is also essential.
- Research on work and retirement, program cost containment initiatives, and long-term care must also receive high priority. The strong rationale for such studies is developed in the chapters of this National Policy on Aging.
- Increased study of senile dementias, including those of the Alzheimer's type, is urgently needed.
- The necessary supports for aging research must be protected to ensure a continuing capacity to advance geriatric knowledge.
- Research knowledge must continue to be disseminated with maximum effectiveness.
- The Department of Health and Human Services should meet with private foundations and corporations to coordinate aging research activities and to encourage their increased participation in aging research.
- Cooperation and coordination of aging research among American scientists should be fostered, and liaison with the scientists of other countries should be continued.

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